OUT-PATIENT AND EMERGENCY RECORD

FAMILY NAME | FIRST NAME | MIDDLE NAME | HOME PHONE | ADMISSION DATE TIME A.M. P.M. | HOSPITAL NO.

ADDRESS | CITY | ZONE | STATE | BIRTH DATE MO. DAY YEAR | AGE | SEX M F | CIVIL STATUS M S W D SEP. | RELIGION

NEAREST RELATIVE OR FRIEND _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

EMPLOYER _____ ADDRESS _____ PHONE _____

OCCUPATION _____ BROUGHT BY _____

NURSES

INSURANCE INFORMATION

BLUE CROSS: CONTRACT NO. 528-22-1686 GROUP NO. 94001 CODE _____

OTHER _____ IDENTIFICATION NO. _____

INSURED THROUGH SELF ☐ SPOUSE ☐ FATHER ☐ MOTHER ☐ ADMITTED BY _____

ACCIDENT: INDUSTRIAL ☐ OTHER ☐ TIME OF ACCIDENT _____ A.M. P.M. OTHER INFORMATION _____

WHERE AND HOW OCCURRED _____

ILLNESS: C. C. _____

ONSET _____

T. B.P. PULSE NURSE IN ATTENDANCE _____, R.N.

PHYSICIAN

P. EXAM: _____

Dx: _____

Rx: _____

FINAL DISPOSITION: _____

☐ HOME ☐ HOSPITAL ☐ OTHER _____

☐ RELATIVES ☐ POLICE ☐ CORONER NOTIFIED _____ A.M. P.M. BY _____

☐ DR. EMERGENCY ROOM SERVICES $ 20.00 SIGNED _____ (PHYSICIAN)

OFFICE

CHARGES:

☐ Emergency Room ..... $ _____

☐ Central Supply ..... _____

☐ Laboratory ..... _____

☐ X-ray ..... _____

☐ Pharmacy ..... _____

☐ Oxygen ..... _____

☐ Other ..... _____

TOTAL ..... $ _____

Bill rendered to _____

Address _____

☐ Billed ☐ Paid Date _____

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT

I, THE UNDERSIGNED, A PATIENT IN THIS HOSPITAL, HEREBY AUTHORIZE DR. _____ (AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANTS) TO ADMINISTER SUCH TREATMENT AS IS NECESSARY, AND TO PERFORM THE FOLLOWING OPERATION _____ AND SUCH ADDITIONAL OPERATIONS OR PROCEDURES AS ARE CONSIDERED THERAPEUTICALLY NECESSARY ON THE BASIS OF FINDINGS DURING THE COURSE OF SAID OPERATION. I ALSO CONSENT TO THE ADMINISTRATION OF SUCH ANESTHETICS AS ARE NECESSARY, WITH THE EXCEPTION OF _____. ANY TISSUES OR PARTS SURGICALLY REMOVED MAY BE DISPOSED OF BY THE HOSPITAL IN ACCORDANCE WITH ACCUSTOMED PRACTICE. I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENT, THE REASONS WHY THE ABOVED NAMED SURGERY IS CONSIDERED NECESSARY, ITS ADVANTAGES AND POSSIBLE COMPLICATIONS, IF ANY, AS WELL AS POSSIBLE ALTERNATIVE MODES OF TREATMENT, WHICH WERE EXPLAINED TO ME BY DR. _____. I ALSO CERTIFY THAT NO GUARANTEE OR ASSURANCE HAS BEEN MADE AS TO THE RESULTS THAT MAY BE OBTAINED.

SIGNATURE OF PATIENT _____

SIGNED FOR PATIENT BY _____

RELATIONSHIP _____ DATE _____ TIME _____ A.M. P.M.

WITNESS _____

REASON PATIENT CANNOT SIGN _____